ProCare Rx

Immune Globulins Intravenous

Ticket #: _____ **Request Date:** _____ **Request Time:** _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **immune globulins intravenous**. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information		
Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC # and GCN:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1. What is the patient's current diagnosis?
   - ☐ Primary Immune Deficiency Disease
   - ☐ Immunodeficiency Syndrome
   - ☐ Idiopathic Thrombosytopenic Purpura (ITP)
   - ☐ B-cell Chronic Lymphocytic Leukemia (CLL)
   - ☐ Kawasaki Disease
     (If YES, provide date of onset. Date: _____/_____/_____)
   - ☐ Bone marrow transplantation
     (IF YES, provide date and type. Date: _____/_____/_____ & Type: _____)
   - ☐ Pediatric HIV infection
     (If YES, provide date and result of last CD4 count. Date _____/_____/_____ & Count _____)
2. Will the medication be administered at MD's office? YES NO
3. If NO, does the physician believe that the administration of IVIG in the patient's home is medically appropriate? YES NO

   Provide rate of administration: _____

   Note: Rate of administration may require adjustment for members with or at risk for renal dysfunction.

PLEASE PROVIDE SUPPORTING CHART DOCUMENTATION

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.